OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Discharge Data

Individual Hospital Transmittal Form
(OSHPD 1370.1)

OSHPD Use Only

PM Date:_____

Batch:_____

Abst:_____

A. Hospital Name: _____

B. Hospital Six Digit Identification Number: | | | | | | |

C. Report Period From: _____/_____/_____ To _____/_____/_____

D. Total Number of Records: _____

MAGNETIC TAPE REPORTING: (Specify the magnetic tape format)

[ ] 9 Track, 6250 BPI [ ] 9 Track, 1600 BPI [ ] IBM 3480 Compatible Cartridge

[ ] IBM Standard Labels [ ] Unlabeled

[ ] EBCDIC [ ] ASCII

Block Size:_____

DISKETTE REPORTING: (Specify the diskette size and filename)

[ ] 8" Diskette [ ] 5¼" Diskette [ ] 3½" Diskette

Filename:_____

CERTIFICATION

I, _____, certify under penalty of perjury as follows:
(Name of Individual)

That I am an official of _____ and am duly authorized to sign this certification; and
(Name of Hospital)

that, to the extent of my knowledge and information, the accompanying discharge abstract data records are true and correct, and that the definitions of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated:_____ By:_____
(Signature)

Hospital:_____ Name:_____
(Please Print)

Address:_____ Title:_____

_____ Phone:_____